Dental Mouthwash Order Form

Patient Full Name: _____Patient DOB: _____

Patient Phone #:_____

Patient Address: _____ City: _____ State: _____

- ☐ Maalox (Antacid) Qty#:_____
- ☐ Viscous Lidocaine 2% Qty#:_____
- ☐ Diphenhydramine 12.5mg/mL Solution Qty#:_____
- ☐ Nystatin 100,000U/mL Suspension Qty#:_____
- ☐ Tetracycline Qty/Strength:_____
- ☐ Hydrocortisone Qty/Strength:_____
- ☐ Dexamethasone Solution 0.5mg/5mL Qty/Strength:_____
- ☐ Prednisolone 15mg/5mL Solution Qty/Strength:_____
- ☐ Other Ingredient:_____ Qty/Strength:_____

Total Volume Dispensed #:_____mL Refills:_____

- ☐ SIG: Swish and spit 5ml to 10ml by mouth every 4 to 6 hours as needed.

OR

OTHER SIG:_____

_____

- ☐ Oral Numbing Dental Paste (Indicate Strength of Each Ingredient, Leave Blank if it isn't being used)

Benzocaine_____% Lidocaine_____% Prilocaine%_____% Tetracaine_____%

Qty:_____g Refills:_____

Physician Name: _____ NPI or DEA: _____

Office Address:_____ Office Phone Number: _____

Signature: _____